FOREWORD

The benefits described in this booklet are provided under the self-funded State Preventive Dental Plan administered by Delta Dental Plan of Michigan, Inc. (Delta Dental) under the direction of the Department of Civil Service, Employee Benefits Division (DCS, EBD). These benefits are not insured with Delta Dental but will be payable from funds administered by DCS, EBD.

DCS, EBD is responsible for implementing State Preventive Dental Plan benefits and future changes in benefits. Delta Dental will provide certain services on behalf of DCS, EBD through an administrative services only contract. Information concerning people enrolled under the State Preventive Dental Plan may be reviewed by Delta Dental Plan of Michigan, Inc.

Every effort has been made to ensure the accuracy of this benefit booklet. However, if statements in this booklet differ from applicable Delta Dental coverage documents, then the terms and conditions of those coverage documents will prevail.

For additional information on the State Preventive Dental Plan, contact your personnel office or write to:

Delta Dental
Customer and Claims Services Department
P.O. Box 30416
Lansing, Michigan 48909-7916

The State Preventive Dental Plan is designed to encourage preventive dental care and assist you with the financial burden of dental bills. Please keep in mind that this Plan is not intended to cover the cost of all services. You should continue to discuss your dentist's charges with the dentist in advance of any treatment to determine your share of the cost.

This booklet includes references to coverage and benefits that are legally enforceable and that the Plan is maintained for the exclusive benefit of employees. Employee participation in this plan can be terminated by the employee at any time.

DELTA DENTAL

Customer and Claims Services

If you have any questions that are not answered in this benefit booklet, or if you would like the names of DPO member dentists in your area, please call the Customer and Claims Services department at Delta Dental Plan of Michigan:

(800) 524-0150 Monday through Friday

This is also available in alternative accessible formats upon request.

Or use Delta Dental's online Dentist Directory at:

www.deltadental.com

You may send written inquiries to:

Delta Dental Plan of Michigan
Customer and Claims Services
P.O. Box 30416
Lansing, Michigan 48909-7916

Please include your group name (State of Michigan), your group number (8700), the subscriber's Social Security number, and your daytime telephone number on any written inquiries.

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ELIGIBILITY GUIDELINES

Employees

You are eligible to enroll in the State Preventive Dental Plan on the first day of the biweekly payroll period following your enrollment if you are:

- a Full-Time (FT) employee;
- a Part-Time (PT) or Job Sharing (JS) employee working 32 hours or more every biweekly pay period; or
- a Permanent Intermittent (PI) employee expected to work every biweekly pay period and at least 40 percent of full-time annually (a minimum of 832 hours).

A seasonal employee must have an appointment lasting eight months or more a year.

Certain unclassified state employees are also eligible to enroll.

Your coverage is effective on the first day of the first pay period after you enroll provided you are not both disabled and away from work on that day. If you are both disabled and away from work on the day your dental coverage would become effective, your coverage will then go into effect on the first day of the first pay period you return to work.

An eligible employee who is not enrolled but is covered by the enrollment of a spouse or parent with another employer may enroll before or within 31 days after termination of the spouse's or parent's coverage. The effective date of coverage is the first day of the pay period after the date of termination or after enrollment, whichever is later.

Dependents

You may enroll your legal spouse and any of your unmarried children up to the end of the pay period after their 19th birthday or up to age 25 if they are unmarried, regularly attending school, and primarily dependent on you for support. These dependents can include:

- your children by birth, legal adoption, or legal guardianship while they are in your custody and dependent on you;
- an other unmarried child who lives with you in a parent-child relationship, is regularly attending school, and depends solely on you for support; or
- your children by birth or legal adoption who do not reside with you, but are your legal responsibility for the provision of medical care (e.g., children of divorced parents).

When your dependents are properly enrolled at the time you enroll, your dependent's State Preventive Dental Plan coverage is effective the same day as yours.

Dependents in the Armed Forces

No person will be considered a dependent while in the armed forces of any country.

Dependents Between the Ages of 19 and 25

Dependent children who meet the eligibility requirements listed below may continue to be covered under the State Preventive Dental Plan as a continuation member after they reach the age of 19. This dependent coverage may continue up to the age of 25 if they remain eligible. Coverage for these dependents will be exactly the same as yours.

To be eligible, these dependents must meet **all** the following requirements.

Your natural or adopted child may be covered as a dependent as long as he or she is

- unmarried and under age19; or
- unmarried, under age 25, regularly attending school, and dependent on you for support as defined by IRS regulations.

Any other child (stepchild, grandchild, etc.) may be covered under the dental care option as long as he or she is:

- unmarried, under age 19, living with you in a parent-child relationship, and dependent on you for support as defined by IRS regulations; or
- unmarried, under age 25, regularly attending school, and dependent on you for support as defined by IRS regulations.

Incapacitated Children

If your enrolled dependent is an incapacitated child, your coverage for this child will automatically continue at and beyond age 19 as long as he or she continues to be incapacitated and provided coverage does not terminate for any other reason. Your child will be considered incapacitated if he or she is unable to earn his or her own living because of a mental or physical impairment and he or she depends chiefly on you for support and maintenance. The disability must have

started before the 19th birthday. Before your child turns 19, you must contact your personnel office for additional information on the continuation of coverage. Proof that your child is incapacitated may be requested periodically thereafter.

Dual Enrollment

No person may be covered as both an "employee" and "dependent" nor as a dependent child of more than one employee. If you and your spouse are both employed by the State of Michigan, dental coverage may be carried separately or as one enrollment with dependent coverage. If you maintain separate enrollments, your children may NOT be listed on both your and your spouse's (or your and your ex-spouse's) State Preventive Dental Plan, State Dental Plan, or the combination of the two.

Should you or your spouse separate from State service, take a leave of absence, or become laid off, the departing employee and eligible enrolled dependents may be enrolled as dependents on the remaining employee's State Preventive Dental Plan, providing the remaining employee:

- was covered as a dependent of the departing employee or was enrolled separately as an employee; and
- continues to meet the eligibility requirements.

Once you return to work, you must wait until the State's next Open Enrollment period before you may transfer your coverage back into your own name.

Applying for Coverage

You may apply for dental coverage when you meet State Preventive Dental Plan requirements for eligibility. Your employer will provide you with an application form and you may enroll yourself and your eligible dependents before or within 31 days after your eligibility date.

An eligible employee who is not enrolled but is covered by the enrollment of a spouse or parent with another employer may enroll before or within 31 days after termination of the spouse's or parent's coverage. The effective date of coverage is the first day of the payroll period after the date of termination or after enrollment, whichever is later.

When your dependents are properly enrolled at the time you enroll, their State Preventive Dental Plan coverage is also effective the same day as yours.

If you do not enroll when newly hired, or if you do not enroll your eligible dependents at that time (or when newly acquired), you will be given other opportunities to enroll or add to your enrollment during Open Enrollment periods or in the event of a "family status change" (described below).

Family Status Change

Mid-year changes in your enrollment will be allowed during the benefit year based on what the Internal Revenue Service (IRS) calls a "family status change." These changes occur if you lose or need coverage because:

- you get married or divorced;
- a child is born, adopted, or moves into your home in a "parent-child relationship;
- your spouse begins or ends employment;
- your spouse changes from part-time to full-time (or vice versa) or takes an unpaid leave of absence resulting in a significant change in your coverage; or
- there is a significant change in your coverage (or your spouse's coverage) through your spouse's (non-State of Michigan) employer plan.

If you wish to enroll a newly acquired dependent after your coverage becomes effective, or if another family status change occurs, notify your personnel office in writing within 31 days. **If you fail to enroll a newly acquired dependent within 31 days of acquiring that dependent, you will have the opportunity to add to your enrollment during the next Open Enrollment period.**

The coverage effective date for a newly acquired dependent will be the date he or she is acquired (by birth, adoption, marriage, divorce, etc.). The effective date for any other family status change will be the first day of the payroll period following the family status change or after enrollment, whichever is later.

Transfer to Another State Agency or Employee Bargaining Unit

If you transfer from one State agency or another, your existing enrollment will be transferred automatically to the new agency without interruption. If you transfer from one employee bargaining unit to another, your enrollment will be transferred automatically and will reflect changes in certain collectively bargained benefits or premium contributions, if any.

Open Enrollment Period

If you are not already enrolled, you may register to enroll during an announced Open Enrollment period. If

you are already enrolled, you may change your existing enrollment to include eligible dependents. However, in order to newly enroll yourself or an eligible dependent, you must be actively at work or receiving workers' compensation benefits on the effective date of the enrollment or change. The effective date of your enrollment or change will be as prescribed in the Open Enrollment materials.

Cancellation of Coverage

Employees

An election may be revoked or changed at anytime if the change is the result of a change in family status as defined under Internal Revenue Code Section 125. The cancellation effective date will be the last day of the last payroll period in which a premium is paid.

Your coverage under the State Preventive Dental Plan will automatically terminate (except as explained under "Continuation of Coverage") in the event of the following, whichever occurs first:

- when your employment terminates;
- when you are no longer in an eligible classification of employees;
- on the last day of the last payroll period for which you made a required premium contribution; or
- when the entire group contract is discontinued.

Dependents

An election may be revoked or changed at anytime if the change is the result of a change in family status as defined under Internal Revenue Code Section 125. The cancellation effective date will be the last day of the last payroll period in which a dependent contribution is paid. In the event of divorce, the spouse' cancellation effective date will be the date of divorce.

Your dependent's coverage will automatically terminate (except as explained under "Continuation of Coverage") in the event of the following, whichever occurs first:

- when your dependent becomes eligible for coverage as an employee;
- when your coverage terminates;
- when your dependent no longer meets the definition of an eligible dependent (Note: Ex-spouses are not eligible);
- on the last day of the last payroll period for which you made any required dependent premium contribution; or
- when the entire group and/or the group dependent contract is discontinued.

Loss of Eligibility During Treatment

If you or your eligible dependent should lose eligibility while receiving dental treatment, only those covered services actually received while you or your eligible dependent were covered under the plan will be considered a covered expense.

Certain procedures begun before the loss of eligibility may be covered provided that the services were completed with a 60-day period measured from the date of loss of eligibility. In those cases, Delta Dental investigates those services in progress to determine what portion, if any, is payable by the State Preventive Dental Plan through Delta Dental. The balance of the total fee is your responsibility.

Continuation of Coverage

When your enrollment or your dependent's enrollment in the State Preventive Dental Plan has been cancelled, you or your dependent may be eligible for the continuation of benefits as explained below.

Retirement

If you retire any time prior to the end of the month with a pension beginning the first of the month, coverage as an active employee is automatically continued to the end of the month.

Death of Employee

In the event of your death, State Preventive Dental Plan coverage will automatically continue for your dependent if he or she will receive an immediate monthly pension benefit from the State of Michigan.

If your dependent is not going to receive a monthly pension benefit following your death, coverage will end 30 days following your death unless your dependent continues State Preventive Dental Plan coverage pursuant to Federal COBRA regulations. (See "COBRA Continuation.")

COBRA Continuation

You and your enrolled dependents may continue terminated State Preventive Dental Plan coverage for up to 18 months by paying the full monthly premium (including the share that is paid by the State) directly to the State if the coverage is terminated because of either the employee's suspension or reduction in the employee's work hours (including a PT/PI "furlough"); or the employee's termination from employment (including deferred retirement), unless the termination was for gross misconduct.

Enrolled dependents may also continue State Preventive Dental Plan coverage for up to 36 months by paying the full monthly premium (including the share that is paid by the State) directly to the State. Dependents may continue coverage if the coverage is terminated as a result of the employee's death, divorce, or legal separation (if the legal separation caused the loss of coverage).

COBRA Notification and Application

You or a family member must notify your personnel office when divorce or legal separation occurs or when a dependent child is no longer eligible. For all other qualifying events, your personnel office will notify you and your enrolled family members of your right to continue terminated coverage.

In any case, you (or your dependents) must apply for the continuation of terminated coverage by submitting an Application for Continuation of Insurance (form DMB-1499 CS) to the Employee Benefits Division no later than 60 days from the date of your qualifying event or the date coverage ended, whichever is later. This continuation opportunity will end if an application is not submitted or the full State premium is not paid within the stated time limits.

While the Employee is on a Layoff

If you are an employee on a layoff, you may continue terminated State Preventive Dental Plan coverage for yourself and your enrolled dependents for up to 18 months by paying the full monthly premium (including the share that is paid by the State) directly to the State. You can elect to pre-pay the "employee's share" of the biweekly premium covering the first two pay periods after the layoff by having the premiums deducted from your last pay check. The State will then contribute the "State's share." This four-week "pre-paid period" will not extend the 36-month time period allowed for the continuation of active coverage.

While the Employee is on a Leave of Absence

If you are an employee on a leave of absence, you may continue terminated State Preventive Dental Plan coverage for you and your dependents for up to 18 months by paying the full monthly premium (including the share that is paid by the State) directly to the State.

SUMMARY OF BENEFITS

Enrolled employees and covered dependents are entitled to those covered dental services listed below to the extent specified in bargaining unit contracts or the Compensation Plan.

Class I Benefits

Diagnostic Services – 100%

Services and procedures used to evaluate existing conditions and the dental care required. Oral examinations are limited to twice in a Plan year.

Preventive Services – 100%

Dental procedures or techniques to prevent the occurrence of dental abnormalities or disease. Covered services include:

- three prophylaxes (teeth cleanings), including periodontal prophylaxes, in a Plan year;
- fluoride treatments for enrolled dependents under age 19; and
- space maintainers for enrolled dependents under age 14.

Radiographs – 100%

X-rays as required for routine care or as necessary for the diagnosis of a specific condition. Covered services include full mouth X-rays once in every five years and bitewing X-rays once in a Plan year unless special need is shown.

EXCLUSIONS

No payment will be made by Delta Dental for the following services. All charges for the following services will be the responsibility of the Subscriber (though the Subscriber's payment obligation may be satisfied by insurance or some other arrangement for which the Subscriber is eligible):

1. Services for injuries or conditions payable under Workers' Compensation or Employer's Liability laws. Benefits or services that are available from any

government agency, political subdivision, community agency, foundation, or similar entity. NOTE: This provision does not apply to any programs provided under Title XIX Social Security Act, that is, Medicaid.

2. Services, as determined by Delta Dental, for correction of congenital or developmental malformations, cosmetic surgery, or dentistry for aesthetic reasons.
3. Services or appliances started before an individual became eligible under this Plan.
4. Prescription drugs (except intramuscular injectable antibiotics), premedications, medicaments/ solutions, and relative analgesia.
5. General anesthesia and/or intravenous sedation for restorative dentistry or for surgical procedures.
6. Charges for hospitalization, laboratory tests, and histopathological examinations.
7. Charges for failure to keep a scheduled visit with the Dentist.
8. Services, as determined by Delta Dental, for which no valid dental need can be demonstrated, that are specialized techniques, or that are investigational in nature as determined by the standards of generally accepted dental practice.
9. Treatment by other than a Dentist, except for services performed by a licensed dental hygienist under the scope of his or her license.
10. Those benefits excluded by the policies and procedures of Delta Dental, including the Processing Policies.
11. Services or supplies for which no charge is made, for which the patient is not legally obligated to pay, or for which no charge would be made in the absence of Delta Dental coverage.
12. Services or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared.
13. Services that are covered under a hospital, surgical/medical, or prescription drug program.
14. Services that are not within the classes of benefits that have been selected and are not in the contract.
15. Fluoride rinses, self-applied fluorides, or desensitizing medicaments.
16. Preventive control programs (including oral hygiene instruction, caries susceptibility tests, dietary control, tobacco counseling, home care medicaments, etc.).
17. Sealants.
18. A space maintainer for maintaining space due to the premature loss of the anterior primary teeth.
19. Lost, missing, or stolen appliances of any type and replacement or repair of orthodontic appliances or space maintainers.
20. Veneers.
21. Oral surgery, restorative services, endodontics, periodontics, prosthodontic services, and orthodontic services.
22. Implants and implant related services.
23. Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint (TMJ).

No payment will be made by Delta Dental for the following services. A Participating Dentist cannot charge a Subscriber or Eligible Dependent for these services. All charges from Nonparticipating Dentists for the following services will be the responsibility of the Subscriber:

1. The completion of claim forms.
2. The fee for a consultation is part of the fee for the examination and/or diagnostic procedures.
3. Infection control.
4. Postoperative radiographs, when done following any completed service or procedure.
5. Periodontal charting, when done on the same day as an oral examination. An examination, when done on the same day as a periodontal prophylaxis.
6. A prophylaxis, when done on the same day as root planing. Root planing, when done on the same day as subgingival curettage.

LIMITATIONS

The benefits for the following services are limited as follows. All charges for the following services will be the responsibility of the Subscriber. All time limitations are measured from the last date of service in any Delta Dental Plan record or, at the request of your group, any dental plan record.

1. Bitewing X-rays are payable once per plan year. Full mouth X-rays (which include bitewing X-rays) are payable

once in any five-year period. A panographic X-ray (including bitewings) is considered a full mouth X-ray.

2. Prophylaxes, including periodontal prophylaxes, are payable three times per plan year. Oral exams are payable twice per plan year. Preventive fluoride treatments are payable twice per Plan year for Children until their 19th birthday.
3. A space maintainer is a benefit for patients up to the age of 14.
4. Delta Dental's obligation for payment of benefits ends on the last day of the month in which coverage is terminated, but it will make payment for Covered Services provided on or before the last day of the month in which coverage is terminated.
5. When services in progress are interrupted and completed later by another Dentist, Delta Dental will review the claim to determine the amount of payment, if any, to each Dentist.
6. Care terminated due to the death of a Subscriber or Eligible Dependent will be paid to the limit of Delta Dental's liability for the services completed or in progress.
7. Processing Policies may limit treatment.

SELECTING A DENTIST

You may choose any Dentist. Your out-of-pocket costs are likely to be less if you go to a DeltaPreferred Option Dentist. DPO Dentists have agreed to accept payment according to the DPO Dentist Schedule, and, in most cases, this results in a reduction of their fees.

If the Dentist you select is not a DPO Dentist, you will have back-up coverage through DeltaPremier. Again, your out-of-pocket expenses will vary depending on the Dentist's participating status. In this case, there are two options:

- If you go to a non-DPO Dentist who participates with DeltaPremier, the fee reduction may not be as great as with the DPO Dentists. However, DeltaPremier Dentists agree to accept Delta Dental's payment and your Copayment as payment in full for Covered Services.
- If you choose a Dentist who isn't participating in either program, you will be responsible for any difference between Delta Dental's allowed fee and the Nonparticipating Dentist Fee or the Out-of Country Dentist Submitted Fee, in addition to any Copayment.

To be sure the Dentist of your choice is a Participating Dentist, you can obtain the names of DPO Dentists and DeltaPremier Dentists by calling (800) 524-0150 or by using Delta Dental's online Dentist Directory at www.deltadental.com.

ACCESSING YOUR BENEFITS

To use your Plan, follow these steps:

1. Please read this benefit booklet carefully to become familiar with the benefits, payment mechanisms, and provisions of your Plan.
2. Make an appointment with your Dentist and tell him or her that you have dental benefits coverage with Delta Dental. If your Dentist is not familiar with your Plan or has any questions regarding the Plan, have him or her contact Delta Dental (a) by writing Delta Dental, Attention: Customer and Claims Services, P. O. Box 30416, Lansing, Michigan 48909-7916, or (b) by calling the toll-free number, (800) 524-0150.
3. After you receive your dental treatment, you or the dental office staff will file a claim form, completing the information portion with:
   a. The Subscriber's full name and address;
   b. The Subscriber's Social Security number;
   c. The name and date of birth of the person receiving dental care;
   d. The group's name and number.

Claims, adjustment requests, and completed information requests should be mailed to:

Delta Dental
P. O. Box 9085
Farmington Hills, Michigan 48333-9085

Delta Dental recommends Predetermination before any services are rendered where the total charges will exceed $200. Predetermination is not a prerequisite to payment, but it allows claims to be processed more efficiently and allows you to know what services will

be covered before your Dentist provides them. You and your Dentist should review your Predetermination Notice before your Dentist proceeds with treatment. Once treatment is complete, the dates of service are entered on the Predetermination Notice and it is submitted to Delta Dental for payment.

Because the amount of your benefits is not conditioned on a Predetermination decision by Delta Dental all claims under this Plan are Post-Service Claims. Once you or your Dentist has filed your claim, Delta Dental will decide the claim within 30 days of its receipt. If there is insufficient information to determine your claim, you or your Dentist will be notified before 30 days has elapsed. The notice will (a) describe the information needed, (b) explain why it is needed, (c) request an extension of time in which to decide the claim, and (d) inform you or your Dentist that the information must be received within 45 days or your claim will be denied. You will receive a copy of any notice that is sent to your Dentist. Once Delta Dental receives the requested information, it will have 15 days to decide your claim. If you or your Dentist fail to supply the requested information, Delta Dental will have no choice but to deny your claim. Once Delta Dental makes a determination about your claim, it will notify you within five days of its decision.

If you have been approved for a course of treatment and that course of treatment is reduced or terminated before it has been completed, or if you wish to extend the course of treatment beyond what was agreed upon, you may file a Concurrent Care Claim seeking to restore the remainder of the treatment regimen previously agreed to or seeking to extend the course of treatment. All Concurrent Care Claims will be decided in sufficient time so that, should your claim be denied (in whole or in part), you will be able to seek a review of that decision before the course of treatment is scheduled to terminate.

You may also appoint an authorized representative to deal with the Plan on your behalf with respect to any benefit claim you file or any review of a denied claim you wish to pursue (see the section on Disputed Claims Review and Appeal Procedures). You should contact your personnel office, call Delta Dental's Customer and Claims Services department, toll-free, at (800) 524-0150, or write them at P.O. Box 30416, Lansing, Michigan 48909-7916, to request a form to fill out designating the person you wish to appoint as your personal representative. While in some circumstances your Dentist may be treated as your authorized representative, generally only the person you have authorized on the last dated form filed with Delta Dental will be recognized. Once you have appointed an authorized representative, Delta Dental will communicate directly with your representative and will not also inform you of the status or outcome of your claim. You will have to get that information from your authorized representative. If you have not designated an authorized representative, Delta Dental will communicate with you directly.

If you have any questions about your Plan, please check with your personnel office or call Delta Dental's Customer and Claims Services department, toll-free, at (800) 524-0150. You may also write to Delta Dental's Customer and Claims Services department, P. O. Box 30416, Lansing, Michigan 48909-7916. When writing to Delta Dental, please include your name, the group's name and number, the Subscriber's Social Security number, and your daytime telephone number.

HOW PAYMENT IS MADE

1. If the Dentist is a DPO Dentist and a DeltaPremier Dentist, Delta Dental will base payment on the lesser of:

   a. The Submitted Amount;

   b. The DPO Dentist Schedule; or

   c. The UCR Fee.

   Delta Dental will send payment to the DPO Dentist, and the Subscriber will be responsible for any Copayment and/or the amount the Dentist charged for any noncovered services.

2. If the Dentist is a DPO Dentist but is not a DeltaPremier Dentist, Delta Dental will base payment on the lesser of:

   a. The Submitted Amount; or

   b. The DPO Dentist Schedule.

   Delta Dental will send payment to the DPO Dentist, and the Subscriber will be responsible for any Copayment and/or the amount the Dentist charged for any noncovered services.

3. If the Dentist is a non-DPO Dentist but is participating in DeltaPremier, Delta Dental will base payment on the lesser of:

   a. The Submitted Amount; or

   b. The UCR Fee.

Delta Dental will send payment to the DeltaPremier Dentist, and the Subscriber will be responsible for any Copayment and/or the amount the Dentist charged for any noncovered services.

4. If the Dentist is not participating in the DPO or DeltaPremier program, Delta Dental will base payment on the lesser of:

   a. The Submitted Amount; or

   b. The Nonparticipating Dentist Fee.

   Delta Dental will usually send payment to the Subscriber, who is responsible for making payment to the Dentist.

5. For dental services rendered by an Out-of-Country Dentist, Delta Dental will base payment on the lesser of:

   a. The Submitted Amount; or

   b. The Out-of-Country Fee.

   Delta Dental will usually send payment to the Subscriber, who is responsible for making payment to the Dentist.

DISPUTED CLAIMS REVIEW AND APPEAL PROCEDURES

After you have filed your claim, should you receive an adverse benefit determination, you or your authorized representative will be notified. An adverse benefit determination is any denial, reduction, or termination of the benefit for which you filed a claim, or a failure to provide or to make payment (in whole or in part) of the benefit you sought, including any such determination based on eligibility, application of any utilization review criteria, or a determination that the item or service for which benefits are otherwise provided was experimental or investigational or was not dentally necessary or appropriate. If you are informed that the Plan will pay the benefit you sought but will not pay the total amount of dental expenses incurred, and you must make a Copayment to satisfy the balance, you may also treat that as an adverse benefit determination.

Your notice of an adverse benefit determination will inform you of the specific reason(s) for the denial, the pertinent Plan provision(s) on which the denial is based, and an explanation of the Plan's review procedures for dental claims, including applicable time limits. The notice will also contain a description of any additional materials necessary to complete your claim, an explanation of why such materials are necessary, and a statement that you have a right to bring a civil action in court if you receive an adverse benefit determination after your claim has been completely reviewed. The notice will also reference any rule, guideline, protocol, or similar document or criteria relied on in making the initial determination, and will include a statement that a copy of such rule, guideline, or protocol may be obtained upon request at no charge. Should the adverse determination be based on a matter of dental judgment or dental necessity, the notice will also contain an explanation of the scientific or clinical judgment on which the determination was based or a statement that a copy of the basis for the scientific or clinical judgment can be obtained upon request at no charge.

If you receive notice of an adverse benefit determination, and if you think that Delta Dental incorrectly denied all or part of your claim, here are the steps you can take:

First, you or your Dentist should contact Delta Dental's Customer and Claims Services department and ask them to check the claim to make sure it was processed correctly. You may do this by calling the toll-free number, (800) 524-0150, and speaking to a telephone representative. You may also mail your inquiry to the Customer and Claims Services department at P.O. Box 30416, Lansing, Michigan 48909-7916. When writing, please enclose a copy of your Explanation of Benefits and describe the problem. Be sure to include your name, your telephone number, the date, and any information you would like considered about your claim. This inquiry is not required and should not be considered a formal request for review of a denied claim. Delta Dental provides this opportunity for you to describe problems and submit explanatory information that might indicate that your claim was improperly denied and allow Delta Dental to correct this error quickly.

Disputed Claims Review Procedure

Whether or not you have asked Delta Dental informally, as described above, to recheck its initial determination, you can submit your claim to a formal first-step review through the Disputed Claims Review Procedure described here. To request a formal review of your

claim, send your request in writing to:

Dental Director
Delta Dental
P.O. Box 30416
Lansing, Michigan 48909-7916

Please include your name and address, the Subscriber's Social Security number, the reason you believe your claim was wrongly denied, and any other information you believe supports your claim. You also have the right to review the Plan and any documents related to it. If you would like a record of your request and proof that it was received by Delta Dental, you should mail it certified mail, return receipt requested.

You or your authorized representative should seek a review as soon as possible, but you must file your request for review within 180 days of the date on which you receive your notice of the adverse benefit determination you are asking Delta Dental to review. If you are seeking review of an adverse determination of a Concurrent Care Claim, you will have to seek review as soon as possible so that you may receive a decision on review before the course of treatment you are seeking to extend terminates.

The Dental Director or any other person(s) reviewing your claim will not be the same as, nor will they be subordinate to, the person(s) who initially decided your claim. The Dental Director will grant no deference to the prior decision about your claim, but rather will assess the information, including any additional information that you have provided, as if he or she were deciding the claim for the first time.

The Dental Director will make his or her determination on review within 30 days of his or her receipt of your request. If your claim is denied on review (in whole or in part), you will be notified in writing. The notice of any adverse determination by the Dental Director will (a) inform you of the specific reason(s) for the denial, (b) list the pertinent Plan provision(s) on which the denial is based, (c) contain a description of any additional information or material that is needed to decide the claim and an explanation of why such information is needed, (d) reference any internal rule, guideline, or protocol that was relied on in making the decision on review and inform you that a copy can be obtained upon request at no charge, (e) contain a statement that you are entitled to receive, upon request and at no cost, reasonable access to and copies of the documents, records, and other information relevant to the Dental Director's decision to deny your claim (in whole or in part), and (f) contain a statement that you may seek to have your claim paid by bringing a civil action in court if it is denied again on appeal.

If the Dental Director's adverse determination is based on an assessment of dental judgment or dental necessity, the notice of his or her adverse determination will contain an explanation of the scientific or clinical judgment on which the determination was based, or a statement that a copy of the basis for that scientific or clinical judgment can be obtained upon request at no charge. If the Dental Director consulted dental experts in the appropriate specialty, the notice will contain the name(s) of those expert(s) consulted.

Disputed Claims Appeal Procedure

Should you receive a notice of an adverse determination by the Dental Director, and you do not agree with the results of the Disputed Claim Review Procedure, you may appeal that decision to the Board of Directors of Delta Dental or its delegee through the Disputed Claims Appeal Procedure described here.

To initiate the Disputed Claims Appeal Procedure, you must file a written request for review before the final appeal date listed in the Dental Director's notice denying your disputed claim. If no date is given in this notice, you have until the date that is 60 days from the date you received your letter denying your claim under the Disputed Claims Review Procedure, or, if later, the date that is 150 days from the date you first submitted your request for review under this Disputed Claims Review Procedure.

Send your written request to the same address listed above for the Dental Director, but instead of sending it to the Dental Director, address it to the Board of Directors or its delegee. Your written request must say why you are seeking further review and why you believe the Dental Director's decision was incorrect. You or your authorized representative may submit any additional materials you believe support your claim. You also have the right to review the Plan and any documents related to it.

In your written request for this second level of review, you may also ask for a hearing with the Board of Directors or its delegee. If the Board of Directors or its delegee, at its sole discretion, decides to convene a hearing, you are entitled, at your own expense, to be represented by legal counsel, to request that a court reporter transcribe the hearing, to present evidence, to request the testimony of witnesses, and to cross-examine witnesses. A decision will be made as soon as possible, but in no event later than 30 days from the date the Board of Directors or its delegee receives your request for this second-level review.

You will receive written notice of the Board of Directors' or its delegee's determination. The notice of any adverse determination by the Board of Directors or its delegee will (a) inform you of the specific reason(s) for the denial, (b) list the pertinent Plan provisions on which the denial is based, (c) reference any internal rule, guideline, or protocol that was relied on when making the decision on review and inform you that a copy can be obtained upon request at no charge, (d) contain a statement that you are entitled to receive, upon request and at no cost, reasonable access to and copies of the documents, records, and other information relevant to the Board of Directors' or its delegee's decision to deny your claim (in whole or in part), and (e) contain a statement that you may seek to have your claim paid by bringing a civil action in court.

If the adverse determination on this second-level review is based on an assessment of dental judgment or dental necessity, the notice of the Board of Directors' or its delegee's adverse determination will contain an explanation of the scientific or clinical judgment on which the determination was based, or a statement that a copy of the basis for the scientific or clinical judgment can be obtained upon request at no charge. If the Board of Directors or its delegee consulted dental experts in the appropriate specialty, the notice will contain the name(s) of those expert(s) consulted.

If your claim is denied in whole or in part after both stages of these required Disputed Claims Procedures have been completed, you have the right to seek to have your claim paid by filing a civil action in court, but you will not be able to do so unless you have completed both of the levels of review described above. If you wish to file your claim in court, you must do so within one year of the date on which you receive notice of the final denial of your claim. If, however, Delta Dental fails to comply with any of the deadlines described above, or fails to adequately inform you of your procedural rights under these Disputed Claims Procedures, you may treat these Disputed Claims Procedures as having been completed and file your claim directly in court. You must, however, file your claim in court within one year of the date you knew, or should have known, of Delta Dental's material failure to comply with the Disputed Claims Procedures.

GENERAL CONDITIONS

Coordination of Benefits (Dual Coverage)

This coordination of benefits provision is designed to provide maximum coverage, but not to exceed 100 percent of the total fee for a given treatment plan.

Please note, for married State of Michigan employees who are both enrolled in the State Dental Plan, there is no coordination of benefits. However, coordination of benefits is available between the State Dental Plan and any other group dental plan.

The primary dental program (as specified below) will pay all of the benefits it would owe as if no other coverage was involved. The secondary program will then pay all of the benefits it would owe as if no other coverage was involved, up to 100 percent of the subscriber's liability under that plan. In no case is any program required to pay more than it would have paid without any coordination of benefits.

The program covering the patient as an "employee" is primary over the program covering the patient as a "dependent."

If a dependent child is covered by both parents, the plan covering the parent whose birthday occurs earliest in the calendar year is primary over the other parent's plan. This birthday rule does not apply when the parents are divorced or legally separated, unless the specific terms of the court decree state that the parents will share custody without stating that one parent is responsible for the dental care expenses of the child. In cases where a court decree designates financial responsibility to one parent, the order of benefits determination is outlined below.

In the case of an enrolled dependent child of divorced or legally separated parents, claims will be paid in the following order of priority:

a. First, the plan covering the child as a dependent of the parent who, under the terms of a divorce decree, has the responsibility for the dental care of the child. In no event will a child be eligible for enrollment unless he or she meets the criteria in the Eligibility section.

b. Next, the plan covering the child as a dependent of the custodial parent.

c. Or next, the plan covering the child as a dependent of the custodial parent's spouse.

d. Or the plan covering the child as a dependent of the non-custodial parent.

If the subscriber (you) is enrolled as a subscriber under more than one plan, the plan that has covered you the longest is primary over the other. However, a program that covers the subscriber as a laid-off or retired employee (or as the dependent of a laid-off or retired employee) will have a lower priority than a plan that does not.

Contact Delta Dental for information on alternative rules that may apply to dental plans issued outside of Michigan.

Subrogation; Right of Recovery

The Plan is designed to pay only those expenses for which payment is not available from another source, including any insurance company, group health plan, or individual. In order to avoid imposing any undue hardship on you or your covered Eligible Dependents in a time of need, the Plan or Delta Dental may pay for Covered Services that may be, or may become, the responsibility of another person, provided that the Plan and/or Delta Dental is entitled to receive reimbursement for those payments. By enrolling in the Plan and applying for benefits from the Plan, you and your Eligible Dependents are subject to, and agree to be bound by, the following terms and conditions:

Assignment of Rights (Subrogation)

By accepting benefits from this Plan, you and your Eligible Dependents automatically assign to the Plan or Delta Dental, as applicable, any rights you or they may have to recover all or part of the amounts paid for the same Covered Services from another source, including another group health plan or insurer, limited, however, to the amount of Covered Services for which the Plan or Delta Dental has paid on behalf of you and/or your covered Eligible Dependent. This assignment allows the Plan or Delta Dental to pursue any claim that you may have against a third party, or its insurer, whether or not you choose to pursue that claim. This assignment also includes, without limitation, the assignment to the Plan and/or Delta Dental of a right to any funds paid by a third party to you or your covered Eligible Dependent, or paid on behalf of you or your Eligible Dependent. This assignment entitles the Plan or Delta Dental to be reimbursed on a first-dollar basis (i.e., to have a first priority claim to any Recovered Funds), whether the funds paid to you or for the benefit of you and/or your Eligible Dependents amount to a full or partial recovery, or whether the funds paid are designated for non-medical or dental charges, attorneys' fees, or other costs and expenses. This assignment also grants the Plan and Delta Dental a right to recover from your no-fault auto insurance carrier in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage, to the extent permitted by law.

Equitable Lien and Other Equitable Remedies

The Plan or Delta Dental shall have an equitable lien against any money or property you or your Eligible Dependents recover from any party, including an insurer or another group health plan, but only to the extent of the Covered Services that the Plan or Delta Dental has paid. This equitable lien also attaches to any payment received from workers' compensation, whether by judgment or settlement, where the Plan or Delta Dental has paid for Covered Services prior to a determination that the Covered Services arose out of and in the course of employment. Payment by workers' compensation insurers or your employer will be deemed to mean that such a determination has been made. This equitable lien shall also attach to any money or property obtained by anybody (including, but not limited to, you, your Eligible Dependent, your or their attorney, any individual entitled to receive any recovered amounts on behalf of you or your Eligible Dependent, and/or a trust established on behalf of you or your Eligible Dependent) that is received as a result of you or your Eligible Dependent exercising your rights of recovery. This money or property shall be referred to in this provision as the "Recovered Funds." The Plan or Delta Dental shall also be entitled to seek any other equitable remedy against any party possessing or controlling any Recovered Funds. At the discretion of the Plan Administrator or Delta Dental, the Plan may reduce payment for any future Covered Services otherwise available to you or your Eligible Dependents under the Plan by an amount up to the total amount of the Covered Services paid by the Plan that is subject to the equitable lien.

This and any other provisions of the Plan set forth in this Certificate concerning equitable liens and other equitable remedies are intended to meet the standards for enforcement under ERISA enunciated in the United States Supreme Court's decision in Great-West Life & Annuity Ins. Co. v. Knudson (2002). These provisions concerning subrogation, equitable liens, and other equitable remedies are also intended to supercede the application of the federal common law doctrines commonly referred to as the "make whole" rule and the "common fund" rule.

Obligation to Assist in the Plan's or Delta Dental's Reimbursement Activities

If you are involved in an automobile accident, or require Covered Services that may entitle you to recover from a third party, and the Plan or Delta Dental advances payment in order to prevent any financial hardship to you or your family, you and your Eligible Dependents have an obligation to help the Plan and/or Delta Dental obtain reimbursement for the amount of the payments advanced for which another source was also responsible for making payment. As part of this obligation, you and your covered Eligible Dependents are required to provide the Plan and/or Delta Dental with any information concerning any other applicable insurance coverage that may be available (including, but not limited to, automobile, home, and other liability insurance coverage, and coverage under another group health plan), and the identity of any other person or entity, and his or her insurers (if known), that may be obligated to provide payments or benefits on account of the same Covered Services for which the Plan made payments.

You and your Eligible Dependents are required to (a) cooperate fully in the Plan and/or Delta Dental's exercise of their right to subrogation and reimbursement, (b) not do anything to prejudice those rights (such as settling a claim against another party without notifying the Plan or Delta Dental or not including the Plan or Delta Dental as a co-payee of any settlement amount), (c) sign any document deemed by Delta Dental or the Plan Administrator to be relevant in protecting the Plan and Delta Dental's subrogation and reimbursement rights, and (d) provide relevant information when requested.

The term "information" here includes any documents, insurance policies, and police or other investigative reports, as well as any other facts that may reasonably be requested to help the Plan and/or Delta Dental enforce their rights. Failure by you or your Eligible Dependents to cooperate with the Plan or Delta Dental in the exercise of these rights may result, at the discretion of Delta Dental or the Plan Administrator, in a reduction of future benefit payments available to you and your Eligible Dependents under the Plan of an amount up to the aggregate amount paid by the Plan or Delta Dental that was subject to the Plan's or Delta Dental's equitable lien, but for which the Plan or Delta Dental was not reimbursed.

Obtaining and Releasing Information

While you are covered by Delta Dental, you agree to provide Delta Dental with any information it needs to process your claims and administer your benefits. This includes allowing Delta Dental to have access to your dental records.

Dentist-Patient Relationship

You and your Eligible Dependents have the freedom to choose any Dentist. Each Dentist maintains the dentist-patient relationship with the patient and is solely responsible to the patient for dental advice and treatment and any resulting liability.

Late Claims Submission

Delta Dental will make no payment for services if a claim for those services has not been received by Delta Dental within 12 months after the services were completed.

Actions

No action on a claim arising out of or related to this Certificate will be brought until 30 days after notice of the claim has been given to Delta Dental. In addition, no action can be brought more than three years after the claim first arose. Any person seeking to do so will be deemed to have waived his or her right to bring suit on such claim.

GLOSSARY

Anesthesia (General) – The condition, resulting from administration of anesthetics, in which the patient is rendered completely unconscious and completely without conscious pain.

Anesthetic – A drug that produces a loss of feeling or sensation, such as novocaine.

Bitewing – Dental X-ray picture showing a part of either the right or left upper and lower jaw.

Control Plan (Delta Dental) – The Delta Dental Plan that contracts with your group. The Control Plan will provide all claims processing, service, and administration for a multi-state group. Your Control Plan is Delta Dental Plan of Michigan. The Control Plan will be referred to as Delta Dental in this document.

Concurrent Care Claims – Claims for benefits where an ongoing course of treatment has been agreed to by Delta Dental and/or the administrator of your Plan and the coverage for that ongoing treatment is reduced or terminated before the agreed-to course of treatment

has been completed. A Concurrent Care Claim may also arise should you request the Plan extend coverage beyond the time period or number of treatments previously agreed to.

Covered Services – The unique benefits selected in your Plan. The Summary of Benefits on page 7 lists the Covered Services provided by the State Preventive Dental Plan.

Delta Dental – Delta Dental Plan of Michigan, Inc., a nonprofit dental health care corporation providing dental service benefits. Delta Dental is not a commercial insurance company.

DeltaPreferred Option USA point-of-service (DPO) – A preferred provider organization program that can reduce your out-of-pocket expenses if you receive care from one of Delta Dental's DPO Dentists. This program has back-up coverage through DeltaPremier USA when treatment is received from a non-DPO Dentist.

DeltaPremier USA (DeltaPremier) – A national fee-for-service dental benefits program that covers you when you go to a non-DPO Dentist.

DeltaUSA – A national program with a nationwide network of Participating Dentists for groups with enrollees in two or more states.

Dental Hygienist – A person who has been trained to remove tartar and stains from the surface of the teeth and who may provide additional services and information on the prevention of oral disease.

Dental Services – Care and procedures employed by dentists for the diagnosis or treatment of dental disease, injury, or abnormal conditions based on valid dental need according to accepted standards of dental practice.

Dentist – A person licensed to practice dentistry in the state or country in which dental services are rendered.

- **DeltaPreferred Option Dentist (DPO Dentist)** – a Dentist who has signed an agreement with the Delta Dental Plan in his or her state to participate in DeltaPreferred Option. A DPO Dentist has agreed to accept Delta Dental's payment and the patient's Copayment, if any, as payment in full for Covered Services.
- **DeltaPremier Dentist** – a Dentist who has signed an agreement with the Delta Dental Plan in his or her state to participate in DeltaPremier. A DeltaPremier Dentist has agreed to accept Delta Dental's payment and the patient's Copayment, if any, as payment in full for Covered Services.

  Wherever a term of this Certificate differs from your state Delta Dental Plan and its agreement with a participating Dentist, the agreement in that state with that Dentist will be controlling.

  To be sure the Dentist of your choice is a Participating Dentist, you can obtain the names of DPO Dentists and DeltaPremier Dentists by calling (800) 524-0150 or by using Delta Dental's online Dentist Directory at www.deltadental.com.
- **Nonparticipating Dentist** – a Dentist who has not signed an agreement with Delta Dental to participate in DeltaPreferred Option or DeltaPremier.
- **Out-of-Country Dentist** – A Dentist whose office is located outside of the United States and its territories. Out-of-Country Dentists are not eligible to sign participating agreements with Delta Dental.

DPO Dentist Schedule – The maximum amount allowed per procedure for services rendered by a DPO Dentist.

Fluoride – A chemical solution that is applied to the teeth for the purpose of preventing dental decay.

Maximum Payment – The maximum dollar amount the Plan will pay in any benefit period for covered dental services.

Nonparticipating Dentist Fee – The maximum fee allowed per procedure for services rendered by a Nonparticipating Dentist.

Out-of-Country Dentist Fee – The maximum fee allowed per procedure for services rendered by an Out-of-Country Dentist.

Plan Year – The time period in which the Plan's payments for Covered Services accumulate toward the maximum payment. The State Preventive Dental Plan's plan year is October to September (except the Scientific and Engineering bargaining units represented by MPES).

Plaque – A sticky substance made up of bacteria, dead tissue cells, and debris that accumulates on the teeth.

Post-Service Claims - Claims for benefits that are not conditioned on your seeking advance approval, certification, or authorization in order for you to receive the full amount of any covered benefit. In other words, Post-Service Claims arise when you receive the dental service or treatment before you file a claim for the benefit payment.

Predetermination (Pre-Service Claims) - An estimate of the costs of Covered Services to be provided. Dentists may submit their treatment plans to Delta Dental before procedures are started. Delta Dental reviews the

treatment plan and advises the patient and the Dentist of what services are covered by your Plan and what Delta Dental's payments may be. Delta Dental's payment for predetermined services depends on continued eligibility and the annual or lifetime Maximum Payments available under your Plan. You are not required to seek a Predetermination. The Covered Services you are entitled to receive under your Plan are not conditioned upon any Predetermination made by Delta Dental. You will receive the same benefits under your Plan whether or not you or your Dentist request a Predetermination. Predetermination is merely a convenience so that you will know before the dental service is provided how much, if any, of the cost for the services the Dentist is proposing to perform is not covered under your Plan. Since you may be responsible for any cost not covered under your Plan, this will likely be useful information to know when deciding whether to incur those costs.

Processing Policies – Delta Dental's policies and guidelines used for Predetermination and payment of claims. The Processing Policies may be amended from time to time.

Prophylaxis – Removal of tartar and stains from the teeth.

Space Maintainers – A fixed or removable appliance to prevent the movement of teeth, usually in children.

State of Michigan Preventive Dental Plan – (State Preventive Dental Plan or Plan) is the self-insured fee-for-service/cost management program that provides dental benefits to enrolled members. The State Dental DPO plan covers you when you have services that are rendered by a DPO member dentist. The State Dental Standard plan covers you when you have services that are rendered by a non-DPO dentist.

Subscriber – An eligible employee enrolled in the State of Michigan Preventive Dental Plan. A subscriber may enroll his or her eligible dependents.

Submitted Amount or Submitted Fee – The fee a Dentist bills to Delta Dental for a specific treatment.

UCR – A system used by Delta Dental to determine the approved fee for a given procedure for a given DeltaPremier Dentist.

- **Usual**: The lowest fee regularly charged, offered, or received by an individual Dentist for a dental service. There may be some exceptions for fees charged under preferred provider plans or charitable programs.
- **Customary**: The maximum fee that the local Delta Dental Plan will approve for a given procedure in a given region and/or specialty, under usual circumstances.
- **Reasonable**: A fee that is approved based on unusual circumstances, by report.

A fee meets UCR requirements if it is the lowest of the Submitted Amount; the Usual and Customary fees for the procedure, Dentist, specialty, and region; or if it is Reasonable considering the circumstances. Participating Dentists are not allowed to charge Delta Dental patients more than the UCR amount that is approved by the Delta Dental Plan for the Covered Service.

In all cases, Delta Dental will make the final determination about what is the Usual, Customary, and/or Reasonable fee for the Covered Service.

Urgent Care Claims – A form of a Pre-Service Claim that is not required under this Plan and is generally not applicable to the Plan.

Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to Delta Dental, you can help lower these costs by calling the toll-free hotline. Only anti-fraud calls can be accepted on this line.

ANTI-FRAUD TOLL-FREE HOTLINE:

(800) 524-0147

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.